Medical Referral Form for Women and Infants
Massachusetts WIC Program

Mother's name: _____ **Infant's name:** _____

Infant's DOB: _____

Clinician: Please complete this section - WIC eligibility will depend on this information.
Applicant authorization appears on the reverse side of this form.

EDD ___ /___ /___ Pregravid weight _____ lb

Date prenatal care began ___ /___ /___

Gravida _____ Para _____#TAB _____ #SAB _____

Date of prior delivery / termination, if any: ___ /___ /___

Vaginal _____ C/S _____

Date of delivery / termination ___ /___ /___

Weeks gestation _____ Weight at labor _____ lb

Postpartum weight _____lbs

Date ___ /___ /___

For women and infants >6 months:

One blood test required	Date taken:
HGB _____ gm	___ /___ /___
or	
HCT _____ %	___ /___ /___

For pregnant women, blood must be taken for current pregnancy. For postpartum women, blood must be taken after delivery.

For infant:

Birth weight _____ lb _____ oz

Birth length _____ in

Current weight _____ lb _____ oz

Current length _____ in

Date ___ /___ /___

Update immunization book or attach copy of record or give dates:

	DTaP	Polio	MMR	Hib	Hep B	VZV	PCV 7
First							
Second							
Third							
Fourth							

Please note all that apply:

Woman

- ☐ Hypertension
- ☐ Diabetes/gestational diabetes
- ☐ Smoking
- ☐ Substance abuse, _____
- ☐ Eating disorder, _____
- ☐ Chronic asthma
- ☐ Iron deficiency anemia
- ☐ Depression / mental illness / retardation
- ☐ Please provide breastfeeding support

Woman	Infant	
☐	☐	Traumatic injury / burns / surgery
☐	☐	Infectious disease, _____
☐	☐	Congenital anomaly, _____
☐	☐	Food allergy or intolerance, _____
☐	☐	R_X medication, _____
☐	☐	Other medical concerns: _____

_____

_____

_____
signature of clinician

_____ ___ /___ /___
clinician's name (please print) date

_____ — _____ — _____
phone

_____ — _____ — _____
fax

_____
health center / hospital

_____
street

_____ _____
city zip

Send completed form to:

Medical Referral Form for Women and Infants
Massachusetts WIC Program

Applicant Authorization: Please complete this section.

Your name _____ (Print Name)

Street _____ Apt. _____

Phone ____ – ____ – ____

On WIC before? Yes ☐ No ☐

Infant's name _____ (Print Name)

City _____ Zip _____

Mother's date of birth ___ /___ /___

Infant's date of birth ___ /___ /___

Language spoken _____

I, _____ (Print Name) give permission to _____ (Doctor, Nurse, Healthcare Provider) to release to WIC information on the MRF, which appears on the other side of this form, for determining my nutritional risk for WIC eligibility.

- I understand that I do not have to give my doctor, nurse, or healthcare provider permission to share information about me and my child with WIC. If I choose not to give this permission, to receive WIC benefits I will need to give permission directly to WIC to obtain my height, weight, and bloodwork and my infant's length and weight at the WIC office.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to my provider and send it or bring it where I am now giving permission:

_____
(address of Doctor, Nurse, Healthcare Provider)

If the information has already been given out, I understand that it is too late for me to change my mind and cancel the permission.

Authorized Signature: _____

Relationship to Participant: _____

Date: ___ /___ /___

This authorization is valid for 60 days after the date the health information (height/weight) is obtained.

WIC staff are required to follow federal law to protect WIC participant confidentiality and cannot re-disclose WIC applicant or participant information except with written consent or as required by law.

(see over)

For WIC use	initials
Date rec'd _____	_____
Appt. _____	_____
Appt. _____	_____
WIC # _____ (W)	WIC # _____ (I)

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